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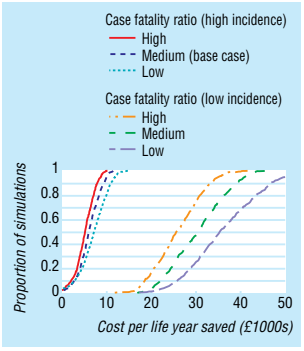
This week in the BMJ

Meningococcal C vaccination is cost effective

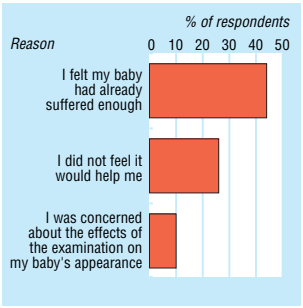


The meningococcal C vaccination campaign, launched in November 1999, has rapidly reduced the incidence of serotype C meningococcal disease in the target age groups. Using cost effectiveness analysis, Trotter and Edmunds (p 809) estimate the cost per life saved to be £6259 and find vaccination to be most cost effective when the incidence of the disease is high. School based vaccination is more cost effective than the routine vaccination of infants because delivery costs are lower and fewer doses are required. Immunisation of infants aged under 1 year was least cost effective, as a three dose schedule is required.

Intensive follow up after surgery for colorectal cancer improves survival

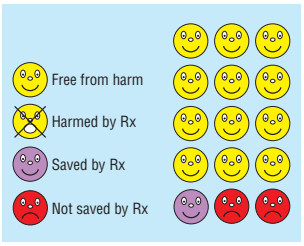
Intensive follow up after colorectal cancer surgery is associated with a reduction in all cause mortality. A systematic review of five trials including 1342 patients by Renehan and colleagues (p 813) found a 9-13% reduction in mortality in trials that used computed tomography and frequent measurements of serum carcinoembryonic antigen to follow up patients. The authors conclude that this reduction is due to all recurrences of cancer, and particularly isolated recurrent disease, being detected early. This study counteracts the lack of direct evidence for intensive follow up after initial curative treatment for colorectal cancer.

Parents recognise benefits of postmortems

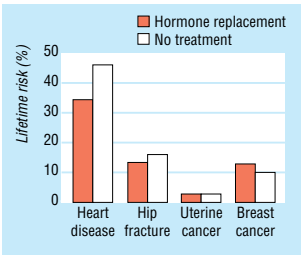


Parents who have lost a baby view the postmortem examination as a useful and necessary tool in helping to discover the reasons why their baby died. The most common reasons given for agreeing to a postmortem examination were wanting more information about what had happened and helping to improve medical knowledge and research, say Rankin and colleagues (p 816). Parents who did not agree to a postmortem examination felt their baby had suffered enough, but some had regrets about their decision. One said: "Now, two years later, I would like to know why they died," and another: "An answer may have alleviated the burden of guilt." The authors say that all medical staff involved in obtaining consent for postmortem examinations should be fully trained in how to ask for parental consent, the postmortem examination procedure, and how to explain the findings.

Visual aids help patients understand risk



Patients want more information in a more understandable format. Decision aids such as booklets, tapes, videodiscs, interactive computer programs, and paper based charts are tools that can easily be used to improve communication. In their clinical review, Edwards and colleagues (p 827) discuss how professionals can support patients in making choices by turning raw data into more helpful information. "Framing manipulations" of information, such as using information about relative risk in isolation of base rates, should be avoided. Decision aids can be useful as they often include visual presentations of risk information and relate the information to more familiar risks.



Change in psychological agreement makes doctors unhappy

One major reason why doctors are unhappy seems to be a change in the relationship between the profession, employers, patients, and society, so that the job is now different to what doctors expected.

PAXTON/FARROW/SPL

Workload and pay, although important, do not fully explain the problem. In response to Richard Smith's editorial (*BMJ* 2001;322:1073-4), Edwards and colleagues (p 835) report on the reasons discussed at seminars on the subject of doctors' unhappiness held in Massachusetts and London last year. They also looked at literature from around the world. They propose that a new agreement that is more acceptable to the profession is needed and that clinical leaders have a crucial role in developing it.

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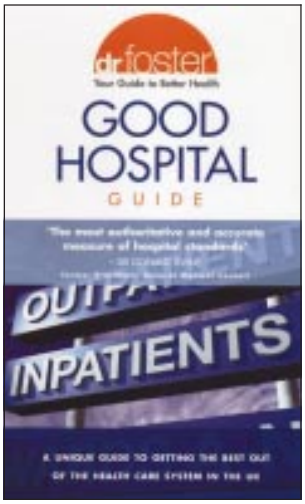
A new agreement is needed if the NHS is to reform

BARRY BATCHELOR/PA

The implicit agreement between the government, the medical profession, and the public (on which the NHS was established) has been undermined over the years and needs to be updated, say Ham and Alberti (p 838). They recommend that a new, explicit agreement is needed, based on patients' rights, public responsibilities, greater accountability of the medical profession, resources, partnerships, support for effective care, and stewardship. Such an agreement can only be reached if representatives of the medical profession, the public, and the government trust each other and believe they are working towards common goals. This will not be easy, they say, but it is essential to enable the different partners to make an effective contribution to the reform of the NHS.



NICE is not fulfilling its promise

The National Institute for Clinical Excellence (NICE) does not currently fulfil its promise to give guidance on interventions of uncertain value and provide clinical guidelines and clinical audit packages. This is because there is ambiguity about how NICE reaches its conclusions and uncertainty about the impact of guidance on the NHS and about who monitors compliance. As a result, NICE's impact is uncertain and geographical inequity in the provision of health services is likely to persist. Dent and Sadler (p 842) consider what NICE needs to succeed and how its chances could be improved. They conclude that there needs to be wider debate about criteria, clarity on status, and more concise recommendations about clinical audit methods.

Editor's choice

Why so unhappy?

Some readers might think we are overdoing "unhappy doctors," but the issue has struck a chord—and not just with doctors. The overwhelming international response to last year's editorial on the subject (2001;322:1073) is highlighted by Nigel Edwards and colleagues in their summary of doctors' views on why doctors are unhappy, gleaned from workshops in Britain and America (p 835). Their main explanation is that the implicit "psychological compact" between doctors, their patients, employers, and governments has changed: there is a "dissonance between what doctors might have reasonably expected the job to be and how it now is."

Chris Ham and George Alberti come to similar conclusions (p 838). They write mainly about Britain, documenting changes in the NHS and British society that have made life increasingly uncomfortable for doctors. They want a new, explicit compact that would acknowledge patients' rights and the need for more accountability but also the need for resources and support for doctors' working lives and better stewardship from the government. "Trust has been strained by failures in clinical performance and the perception on the part of the profession that government has been too ready on some occasions to blame doctors when things go wrong."

Interestingly, the government seems willing to listen. Later this month the Department of Health is hosting a large meeting on "Improving working lives for doctors." Originally planned for a London hotel and with an emphasis on developing flexible working practices, the meeting will now take place in London's flagship conference centre, the QE2, with a broader emphasis on doctor-patient relationships and modernising services and will be attended by the secretary of state for health. This is a deliberate signal that the government has changed tack from bashing doctors to backing them.

As so often, the back end of the journal provides the vignettes that illustrate the larger picture painted by Edwards, Ham, and Alberti. In describing his attempts to come to terms with his stammer Paul Reynolds states how daunting he has found the fact that "medicine favours outwardly 'flawless' individuals" (p 857). Abi Berger reviews Dave Moor's book on being tried (and acquitted) for murder for essentially providing good terminal care—for doing "what just about every doctor … has done at some time … and will continue to do" (p 855). The letters columns continue the debate about euthanasia, with two correspondents demanding to know why it should be doctors who have to do the killing (p 848): why not a philosopher, one suggests.

Yet one attempt to re-establish some pride in medicine gets short shrift. Last Christmas a group of medical students described how their year had decided to make a "declaration" to mark their graduation. William Stevenson dismisses this as "meaningless waffle." All you really need to swear, he says, is " 'I promise to try reasonably hard to do a reasonably good job.' But you have to mean it."